

#### Memorandum

TO: Ryan White Administrative Agency Executive Directors

**Ryan White Administrative Agency Contact Persons** 

FROM: Pamela Mann, Contract Manager

**Contract Management Unit** 

**Division of Prevention and Preparedness** 

DATE: May 16, 2012

SUBJECT: Administrative Agency (HIV/RW) Renewal Request for Fiscal Year 2013 (09/01/12 –

08/31/2013)

Enclosed are the documents required for your agency's Services and Administrative (HIV/RW) contract renewal with the Department of State Health Services (DSHS) for the period September 1, 2012 through August 31, 2013. This document will be posted on the HIV/STD Program's website at: <a href="http://www.dshs.state.tx.us/hivstd/funding/default.shtm">http://www.dshs.state.tx.us/hivstd/funding/default.shtm</a>. Instructions for completing the forms are included below. If you have questions, please contact Pamela Mann at (512) 776-6539.

#### Please note the following requirements for Fiscal Year 2013 Contract Renewal:

- Complete Form A Face Page
- Complete Form B Contact Information Page
- Prepare a 12 month budget for this contract renewal period (09/01/12 8/31/2013). (Revised budget forms are attached.) The administration and service delivery allocations are located in Table A of this document. (\*Please note Do not include State Service budget information in this application. This information will be requested in the separate State Services Contract Renewal Packet.)
- Complete Form G Categorical Budget Justification
- A sample of the revised voucher support form for reimbursement requests is attached.
- Reminder Contractors **shall not** exceed the allocated amount for the administrative costs during this contract term.

(\*Table 1 and Table 2 are <u>not</u> required at this time.)

#### INSTRUCTIONS FOR SUBMISSION

Please submit one (1) electronic copy of the required contract renewal forms to the email address listed below and one (1) electronic copy to your Public Health Regional HIV/STD Program Manager on or before 5:00 pm Friday May 25, 2012. The signed face page must be scanned in as a .pdf file and sent to:

Hiv-srvscontracts@dshs.state.tx.us
Contract Management Unit
Texas Department of State Health Services

Hard copies of contract guidance (forms) are not required for submission.



# **FY 2013**

(09/01/2012 - 08/31-2013)

# Renewal Application Packet For Administrative Agency (HIV/RW)

http://www.dshs.state.tx.us/hivstd/funding/default.shtm

Issue Date: May 16, 2012 Due Date: May 25, 2012

Contract Management Unit
Department of State Health Services
1100 W. 49<sup>th</sup> Street
Austin, Texas 78756-3199

David L. Lakey, M.D. Commissioner

# <u>TABLE A:</u> <u>RWSD/AA 2012-2013 FUNDING ALLOCATIONS\*</u> (For FY13 Contract Renewals 09/01/2012 – 08/31/2013)

ADMINISTRATIVE AGENCY	HSDA'S SERVED	ADMINISTRATIVE AMOUNT	SERVICE DELIVERY AMOUNT	TOTAL CONTRACT AMOUNT
Lubbock Regional MHMR	Lubbock Amarillo Permian El Paso	\$499,500	Lubbock \$328,540 Amarillo \$315,117 Permian \$335,655 El Paso \$1,046,614 <b>Total: \$2,025,926</b>	\$2,525,426
Tarrant County Public Health Department	Abilene Fort Worth Wichita Falls	\$216,000	Abilene \$273,287 Fort Worth \$809,989 Wichita Falls \$199,749 Total: <b>\$1,283,025</b>	\$1,499,025
Dallas County Health and Human Services Dept.	Dallas Sherman-Denison	\$494,000	Dallas \$2,727,475 Sherman-Denison \$181,092 Total <b>:\$2,908,567</b>	\$3,402,567
Houston/East Texas HIV Administrative Service Area (HASA)	Beaumont-Port Arthur Lufkin Houston Galveston Tyler Texarkana	\$650,000	Beaumont-Port Arthur \$597,209 Lufkin \$393,076 Houston \$3,047,346 Galveston \$574,569 Tyler \$725,985 Texarkana \$297,326 Total: <b>\$5,635,511</b>	\$6,285,511
Brazos Valley Council of Governments	Austin Concho Temple Waco College Station	\$426,000	Austin \$968,249 Concho \$176,733 Temple \$332,912 Waco \$336,907 College Station \$300,106 <b>Total:\$2,114,907</b>	\$2,540,907
Bexar County	Uvalde Victoria San Antonio	\$255,000	Uvalde \$268,315 Victoria \$215,110 San Antonio \$920,578 <b>Total:\$1,404,003</b>	\$1,659,003
South Texas Development Council	Laredo Brownsville Corpus	\$274,000	Laredo \$419,193 Brownsville \$1,057,454 Corpus Christi \$513,361 <b>Total: \$1,990,008</b>	\$2,264,008
TOTAL		\$2,164,500	\$11,726,436	\$13,890,936

<sup>\*</sup>Amounts are subject to change.

### **TABLE OF CONTENTS**

### ORGANIZATION AND CONTENT

FORM A:	FACE PAGE	.5
FORM A:	FACE PAGE INSTRUCTIONS	6
FORM B:	CONTACT PERSON INFORMATION	.7
FORM G:	BUDGET CATEGORICAL JUSTIFICATION EXAMPLE	8
FORM H:	RYAN WHITE VOUCHER SUPPORT FORM	.11

#### SEE EXCEL SPREADSHEETS ATTACHED FOR FOLLOWING FORMS:

• BUDGET SUMMARY FORM & ADMIN & SERVICES SUMMARY

#### **Department of State Health Services (DSHS)**

FORM A: FACE PAGE -This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the renewal and shall be completed in its entirety. Signature of face page certifies to all DSHS and program assurances listed in this renewal document.

RESPONDENT IN	NFORMATION
1) LEGAL BUSINESS NAME:	
2) MAILING Address Information (include mailing address, street, city,	county, state and 9-digit zip code): Check if address change
3) PAYEE Name and Mailing Address, including 9-digit zip code (if di	ifferent from above): Check if address change
4) DUNS Number (9-digit) required if receiving federal funds:	
5) Federal Tax ID No. (9-digit), State of Texas Comptroller Vendor ID Nocial Security Number (9-digit):  *The respondent acknowledges, understands and agrees that the respondent's choice to	
may result in the social security number being made public via state open records requ	
6) TYPE OF ENTITY (check all that apply):  City  County  Other Political Subdivision  State Agency  Indian Tribe  Minority Organization*  Community-Based Organization  Minority Organization  Faith Based (Nonprofit of	Federally Qualified Health Centers  State Controlled Institution of Higher Learning  Anization  Hospital  Private
*If incorporated, provide 10-digit charter number assigned by Secretary of	State:
7) PROPOSED BUDGET PERIOD: Start Date: 09/0	01/2012 End Date: 08/31/2013
8) COUNTIES SERVED BY PROJECT:	
AN AMOUNT OF FUNDING PROUPOTED.	L44) PRO IFOT CONTACT REPOON
9) AMOUNT OF FUNDING REQUESTED:	11) PROJECT CONTACT PERSON
10) PROJECTED EXPENDITURES  Does respondent's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for respondent's current fiscal year (excluding amount requested in line 9 above)? **  Yes No	Name: Phone: Fax: Email:  12) FINANCIAL OFFICER
**Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.	Name: Phone: Fax: Email:
The facts affirmed by me in this proposal are truthful and I warrant the respondent is <b>DSHS Assurances and Certifications</b> . I understand the truthfulness of the fact conditions precedent to the award of a contract. This document has been duly author am authorized to represent the respondent.	ts affirmed herein and the continuing compliance with these requirements are
13) AUTHORIZED REPRESENTATIVE Check if chang	e   14) SIGNATURE OF AUTHORIZED REPRESENTATIVE
Name: Title: Phone: Fax: Email:	15) DATE

#### **FORM A: FACE PAGE Instructions**

This form provides basic information about the applicant and the proposed project with the DSHS, including the signature of the authorized representative. It is the cover page of the renewal application and is required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the identified Competitive Request for Proposal and the original DSHS contract, any renewal(s) or amendment(s). Applicant acknowledges that continued compliance is a condition for the renewal of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

- 1) **LEGAL BUSINESS NAME** Enter the legal name of the applicant.
- 2) MAILING ADDRESS INFORMATION Enter the applicant's complete physical address and mailing address, city, county, state, and 9-digit zip code.
- 3) PAYEE NAME AND MAILING ADDRESS Payee Entity involved in a contractual relationship with applicant to receive payment for services rendered by applicant and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address, including 9-digit zip code, if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.
- 4) <u>DUNS Number</u> 9- digit Dun and Bradstreet Data Universal Numbering System (DUNS) number. . This number is required if receiving **ANY** federal funds and can be obtained at: <a href="http://fedgov.dnb.com/webform">http://fedgov.dnb.com/webform</a>
- 5) FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER Enter the Federal Tax Identification Number (9-digit) or the Texas Vendor Identification Number assigned by the Texas State Comptroller (14-digit). \*The applicant acknowledges, understands and agrees the applicant's choice to use a social security number as its vendor identification number for the contract, may result in the social security number being made public via state open records requests.
- TYPE OF ENTITY Check the type of entity as defined by the Secretary of State at <a href="http://www.sos.state.tx.us/corp/businessstructure.shtml">https://fmx.cpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS\_Guide\_0409.pdf</a> and check all other boxes that describe the entity.

Historically Underutilized Business: A minority or women-owned business as defined by Texas Government Code, Title 10, Subtitle D, Chapter 2161. (http://www.window.state.tx.us/procurement/prog/hub/)

State Agency: an agency of the State of Texas as defined in Texas Government Code §2056.001.ii

Institutions of higher education as defined by §61.003 of the Education Code.

MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

- 7) PROPOSED BUDGET PERIOD Budget period for this renewal application has been entered for you.
- 8) **COUNTIES SERVED BY PROJECT** Enter the proposed counties served by the project.
- 9) AMOUNT OF FUNDING REQUESTED Enter the amount of funding per the allocation given from DSHS for proposed project activities (not including possible renewals). This amount must match column (1) row K from the BUDGET SUMMARY used for cost reimbursement budgets.
- 10) PROJECTED EXPENDITURES If applicant's projected federal expenditures exceed \$500,000 or its projected state expenditures exceed \$500,000 for applicant's current fiscal year, applicant must arrange for a financial compliance audit (Single Audit).
- 11) PROJECT CONTACT PERSON Enter the name, phone, fax, and email address of the person responsible for the proposed project.
- 12) FINANCIAL OFFICER Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.
- 13) <u>AUTHORIZED REPRESENTATIVE</u> Enter the name, title, phone, fax, and email address of the person authorized to represent the applicant. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.
- 14) SIGNATURE OF AUTHORIZED REPRESENTATIVE The person authorized to represent the applicant must sign in this blank.
- 15) **DATE** Enter the date the authorized representative signed this form.

## FORM B: CONTACT PERSON INFORMATION

Legal Name of Applicant:	
This form provides information about the appropriate program contacts in the lf any of the following information changes during the term of the contract,	
Executive Director:	Mailing Address (incl. street, city, county, state, & zip):
Title:	
Phone: Ext.	
Fax:	
E-mail:	· ·
Project Contact:	Mailing Address (incl. street, city, county, state, & zip):
Title:	
Phone: Ext.	
Fax:	
E-mail:	
Financial Reporting Contact:	Mailing Address (incl. street, city, county, state, & zip):
Title:	
Phone: Ext.	
Fax:	
E-mail:	
URS Data Manager:	Mailing Address (incl. street, city, county, state, & zip):
Title:	
Phone: Ext.	
Fax:	
E-mail:	
Planning Contact:	Mailing Address (incl. street, city, county, state, & zip):
Title:	-
Phone: Ext.	
Fax:	
E-mail:	
Clinical Services Contact:	Mailing Address (incl. street, city, county, state, & zip):
Title:	
Phone: Ext.	· -
Fax:	
E-mail:	· -

# **FORM G Categorical Budget Justification Example**

Submit a budget justification that follows the below example. Administrative Agencies must also complete the budget summary forms in the excel spreadsheet.

Cost Categories		Administrative Agency \$81,557		RW Service Delivery \$25,000		Total <b>\$106,557</b>	
A.	PERSONNEL	\$	44,604				\$44,604
	Example:  Executive Director (Gonzales) \$3,200/monthly X 5% X 12 = \$1920 Oversees all program activities. Ensures compliance with contract requirements. Provides program/financial information to the Board of Directors. Acts as agency personnel director and public spokesperson. Supervises Program Manager.	\$	1,920	\$	0	\$	1,920
	Quality Management Coordinator (Jones) \$1,500/monthly X 10% X 12 = \$1800 Facilitate collaboration and work with subcontractors, planning bodies and service systems in gathering and analyzing data for purposes of gathering data to evaluate the effectiveness of funded services.	\$	1,800	\$		\$	1,800
	Program Manager (Watson) \$2,580/monthly X 40% X 12 = \$12,384  Supervises AA program activities. Provides needed staff training. Designs and maintains data collection system. Prepares all required program reports. Evaluates staff performance and conducts quality assurance.	\$	12,384	\$		\$	12,384

	HIV Planner (McDade) \$2,375/monthly X 100% X 12 = \$28,500  Evaluate the effectiveness of services, the adequate delivery of services to special populations, facilitate collaboration, implementing a system of gathering current epidemiology HIV/AIDS data for planning purposes.	\$ 28,500		\$ 28,500
B.	FRINGE BENEFITS	\$ 13,176	\$ 0	\$ 13,176
	Example:	\$	\$	\$
	FICA: 7.65% x salaries = Insurance: \$2,160 x 3.55 (# of FTEs) = Worker's Comp: 2.0% x salaries = \$ Unemployment: 2.7% x salaries = \$	3,412 7,668 892 1,204	0 0 0 0	3,412 7,668 892 1,204
C.	STAFF TRAVEL	\$ 1,977	0	\$ 1,977
	Expenses for 3 staff members, Planner, Data Analyst, Data Manager to attend the Texas HIV/STD Conference:     Airfare @ \$175 X 3 staff =     \$525     Lodging @ \$85 X 4 days X 3     staff = \$1,020     Meals @ \$36 X 4 days X 3 staff = \$432	\$ 525 1,020 432	\$	\$ 525 1,020 432
D.	EQUIPMENT	\$	\$	\$ None Requested
E.	SUPPLIES	\$ 1,200	\$ 0	\$ 1,200
	Example: General office supplies to be used by all staff members- \$100 mo x 12 mo	\$ 1,200	\$ 0	\$ 1,200
F.	CONTRACTUAL	\$ 20,000	\$ 25,000	\$ 45,000

E	xample			\$		
	BC Nonprofit providing non-medical ase management to HIV+ clients.			25,000		25,000
m	lurse to provide medical case nanagement monitoring for the D, E, F ISDA's.		\$20,000			\$20,000
G. 0	THER	\$	600			600
	rinting and reproduction of materials cluding client brochures and referral cards.		600			600
\$5	50 per month x 12 months = \$600					
H. TO	OTAL DIRECT COSTS	\$		\$	\$	
	Enter the total of A - G above]	\$	0	\$	\$	
i. IN	NDIRECT COSTS	Ф	U	Ф	Φ	
st s	The maximum rate allowed under an indirect cost agreement approved by a federal cognizant gency or state single audit coordinating agency. A copy of the current rate is attached behind the Budget. Expired rate agreements are not acceptable.  Less than the maximum amount allowed by a deral cognizant agency or state single audit coordinating agency. A copy of the current rate is attached behind the Budget. Expired rate agreements are not acceptable.  Less than the maximum amount allowed by a deral cognizant agency or state single audit coordinating agency. A copy of the current rate is tached behind the Budget.  Applies to local governments only) The maximum atterated in accordance with OMB Circular A-87. A copy of the indirect cost rate proposal certification and apporting documents is on file and is subject to eview by DSHS fiscal monitors, or any of its duly authorized representatives, as well as duly authorized deral or state authorities.  Acopy of the indirect cost rate proposal prepared in accordance with OMB ircular A-87. A copy of the indirect cost rate proposal prepared in accordance with OMB ircular A-87. A copy of the indirect cost rate proposal certification and supporting documents is on the and is subject to review by DSHS fiscal monitors, or any of its duly authorized representatives, as well as duly authorized federal or state authorities.  The maximum amount calculated under a cost location plan must be submitted for review to DSHS to later than the 60th calendar day after the effective attent of the contract.					

# FORM H HIV/RW VOUCHER SUPPORT FORM

Summary of Ryan White Expenditures
To be submitted with <u>EACH</u> reimbursement request

Administrative Agency:		Submission Date <u>:</u>	 /
Contact Person:		_Phone:	
SERVICE DATES:			
Contract Amount			
Administration:			
Expenditure Category	Amount Of Expenditure		
Administration: H25	\$		
Planning and Evaluation: 079	\$		
Quality Management: K18	\$		
Services:			
Subcontractor Direct Services Costs: 424	\$		
Subcontractor Administrative Costs: 297	\$		
Total Reimbursement Request	\$		